Positivity pays off

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Positivity Pays Off: Clients' Perspectives on Positive Compared With Traditional Cognitive Behavioral Therapy for Depression

Nicole Geschwind
Maastricht University

Emke Bosgraaf
Maastricht University and MetGGZ, Maastricht, the Netherlands

Fredrike Bannink
Amsterdam, the Netherlands

Frenk Peeters
Maastricht University

In this qualitative study, we explored the experiences of clients receiving cognitive behavioral therapy (CBT) for major depressive disorder. All participants received 8 sessions of traditional CBT (based on Beck, Rush, Shaw, & Emergy, 1979) and 8 sessions of positive CBT (order counterbalanced). The aim of the study was to examine clients' experience of positive CBT and to contrast this with their experience of traditional CBT. Positive CBT structurally and selectively focuses on better moments (exceptions to the problem as opposed to the problem), strengths, and positive emotions and integrates traditional CBT with solution-focused brief therapy and positive psychology. In addition to conducting interviews with 12 individuals, the second author attended all therapy sessions of 4 clients and observed biweekly supervision sessions as further methods of data collection. Qualitative analysis showed that, despite initial skepticism, clients preferred positive CBT and indicated experiencing a steeper learning curve during positive, compared with traditional, CBT for depression. The popularity of positive CBT was attributable to 4 influences: feeling good and empowered, benefitting from upward spiral effects of positive emotions, learning to appreciate baby steps, and (re)discovering optimism as a personal strength. Qualitative analysis showed that, despite better moments and building positivity efficiently counters depressive symptoms and builds well-being. Clients perceived positive CBT's upbeat tone as stimulating and as motivating for change.

Clinical Impact Statement

Question: How do clients with moderate to severe depression experience positive cognitive behavioral therapy (i.e., CBT with a structural focus on better moments, strengths, and positive emotions)? ***Findings:*** Respondents in this qualitative study perceived the structural focus on better moments, strengths, and positive emotions as enjoyable and motivating for change. ***Meaning:*** Paying explicit attention to positive emotions in psychotherapy may be beneficial, given that respondents appreciated the lightness of tone and viewed exploration of their strengths, shared laughter, and compliments as memorable, motivating, and empowering. ***Next Steps:*** Next steps include replication of these findings in a larger sample receiving only positive CBT (rather than positive CBT as part of their treatment) and exploration of long-term effects, potentially expanding to different disorders and settings.

Keywords: cognitive behavioral therapy, positive cognitive behavioral therapy, solution-focused brief therapy, positive psychology, qualitative research

Nicole Geschwind, Department of Clinical Psychological Science, Faculty of Psychology and Neuroscience, Maastricht University; Emke Bosgraaf, Faculty of Psychology and Neuroscience and Faculty of Health, Medicine, and Life Sciences, Maastricht University, and MetGGZ, Maastricht, the Netherlands; Fredrike Bannink, Independent Practice, Amsterdam, the Netherlands; Frenk Peeters, Department of Clinical Psychological Science, Faculty of Psychology and Neuroscience, Maastricht University.

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Correspondence concerning this article should be addressed to Nicole Geschwind, Faculty of Psychology and Neuroscience, Maastricht University, P.O. Box 616 (UNS40/CPS), 6200 MD Maastricht, the Netherlands. E-mail: Nicole.geschwind@maastrichtuniversity.nl

A multitude of studies have shown that cognitive behavioral therapy (CBT) as initially formulated by Beck et al. (1979; hereafter referred to as "traditional CBT") is effective in the treatment of major depressive disorder (MDD; Driessen & Hollon, 2010). Traditional CBT contains both behavioral activation elements (based on patients' mood and activity registrations) and cognitive elements and a relapse-prevention plan (Beck et al., 1979; Bockting & Huibers, 2011; Strunk, Adler, & Hollon, 2016). Cognitive elements predominantly use Socratic dialog on dysfunctional thoughts during moments when a client's mood dropped (based on completed homework records), and identification of more rational and helpful thoughts. Qualitative studies have indicated that clients benefit from traditional CBT by gaining insight in managing their depression (Barnes et al., 2013). However, response and remission rates of around 60% and 30%, respectively (Cuijpers et al., 2013), suggest room for improvement.

A Stronger Focus on Positive Emotions?

Recent reviews concluded that the promotion of positive emotions should be a main focus in the treatment of depression, in addition to the reduction of negative emotions (Craske, Meuret, Ritz, Treanor, & Dour, 2016; Dunn, 2012; Sewart et al., 2019). Similarly, a study among 535 outpatients treated for MDD suggests that clients' understanding of remission from depression above all involves the presence of positive mental health features such as optimism and self-confidence, and the return to their usual level of functioning (Zimmerman et al., 2006). Clients' understanding of successful treatment for depression thus involves a shift toward flourishing, rather than merely the reduction of depressive symptoms. Meta-analytic findings indicate a small effect of client preference on treatment outcome, with clients who receive a preferred (compared with a nonpreferred) treatment showing significantly better clinical outcomes and experiencing greater satisfaction with treatment, as well as lower dropout rates (Lindhiem, Bennett, Trentacosta, & McLear, 2014; though see Dunlop et al., 2017, 2019). From a client perspective, a stronger focus on positive emotions may thus represent a promising avenue for improving CBT for depression (see also Santos et al., 2013).

The following two arguments further support the idea that a stronger focus on positive emotions could be beneficial in CBT for depression. First, one of the core symptoms of depression is lack of positive emotions. People with MDD also have difficulty disengaging from negative material (Gotlib, Krasnoperova, Yue, & Joormann, 2004; Koster, De Raedt, Leyman, & De Lissnyder, 2010). According to Fredrickson's (2004) broaden and build theory, positive emotions "undo" negative emotions as well as broaden people's range of available thoughts and actions, thereby facilitating exploration of the environment and creative problem-solving, and building (psychological, social, or intellectual) resources. In this way, initially fleeting positive experiences contribute to a subsequent long-term change (a phenomenon termed *upward spiral*; Garland et al., 2010). Structurally redirecting attention to positive (rather than neutral) features and stimulating positive emotions may thus be an efficient antidote for depressive symptoms such as lack of positive emotions, abundance of negative emotions, and negative attentional biases. In line with this argument, several studies suggest that increases in positive emotions are more important in predicting recovery from depression than decreases in negative emotions (Geschwind et al., 2011; Gorwood et al., 2015).

Second, secondary analyses of randomized controlled trials as well as routine outcome measurements of traditional CBT for depression reveal that CBT satisfactorily repairs elevations in negative affect back to general population average levels but fails to enhance positive affect (Dunn, 2019; Widnall, Price, Trompetter, & Dunn, 2019). Similarly, a functional magnetic resonance imaging study found impaired processing of positive stimuli in participants who had recovered from depression (Arnold et al., 2011). Taken together, these findings suggest that psychotherapy in general and traditional CBT in particular could benefit from targeting positive emotions and the processing of positive stimuli more optimally.

Research on positive psychotherapy in the treatment of depression suggests that positive psychology interventions are effective in promoting well-being and reducing depressive symptoms (Bolier et al., 2013; Seligman, Rashid, & Parks, 2006; Sin & Lyubomirsky, 2009; Vazquez et al., 2018). However, effect sizes of positive psychology interventions are small to moderate, and studies were primarily carried out in nonclinical or mildly depressed samples (with the exception of Vazquez et al., 2018). These limitations underscore the need to study the effects of a structural focus on positive emotions in clinically depressed samples.

Positive CBT

Positive CBT is a novel treatment structurally focused on positive emotions (Bannink, 2012). Positive CBT integrates traditional CBT with methods and exercises from solution-focused brief therapy and positive psychology. Positive CBT is directed toward clients' strengths and their desired future. Clients are first invited to provide a detailed description of their goal (their desired future). Positive CBT then uses CBT techniques (e.g., self-monitoring, homework, functional behavioral analysis, and arrow techniques) to zoom in on correlates and consequences of *desired behavior and better moments* (*exceptions to problems* as opposed to undesired behavior and problem instances) and helps clients to identify their contribution to these better moments. Solution-focused brief therapy (Bannink & Jackson, 2011; De Shazer, Dolan, Konnan, & Berg, 2012) provides a framework for maintaining a focus on the goal (the desired future), building on strengths a client already has, and identifying "baby steps" toward the goal. To further stimulate positive emotions, positive CBT uses positive psychology exercises such as the "three blessings exercise" and "practicing optimistic attribution" (Emmons & McCullough, 2003; Seligman, 2006).

To clarify, we do not intend to imply that discussion of positive experiences or strengths shown in coping with difficulties is off-limits in traditional CBT. Similarly, breaking a goal into subgoals (thus reinforcing baby steps) is a commonly used technique in traditional CBT. Nevertheless, the focus on positive emotions and better moments is much more structurally implemented in positive CBT, compared with traditional CBT.

The Current Study

Research on the effectiveness of psychotherapy is sometimes criticized for neglecting clients' perspective (Bohart & Tallman,

2010; Hodgetts & Wright, 2007; Levitt, Pomerville, & Surace, 2016; Valkonen, Hänninen, & Lindfors, 2011). This also holds for research on the effects of CBT (Hallas, 2014). In the current study, we aim to shed light on the experiences of clinically depressed clients with positive CBT in particular. Clients received treatment for MDD at a specialized mental healthcare center. Positive CBT took place in the context of a within-subject clinical trial (Geschwind, Arntz, Bannink, & Peeters, 2019). In this clinical trial, clients received both traditional CBT (based on Beck et al., 1979) and positive CBT (Bannink, 2012) in two blocks of eight sessions each, with the order of blocks randomized (i.e., first traditional CBT, then positive CBT, or vice versa). In the analysis of questionnaire data belonging to this study (Geschwind et al., 2019), positive CBT resulted in a stronger reduction of depression during the second phase of treatment, whereas the reduction of depressive symptoms stagnated in traditional CBT. Independent of treatment phase, positive CBT was associated with more clinically significant change than traditional CBT.

The purpose of the present study was to understand how clients experienced positive CBT. A good understanding of client experiences and preferences can help to optimize treatment delivery in the future. The unique set-up of the combined treatment meant that clients could contrast their experience with positive CBT with their experience of traditional CBT. Specifically, we aimed to identify (a) clients' previous expectations regarding positive CBT, (b) their preference for either traditional or positive CBT after receiving both treatments, and (c) their reasons for a preference. We also sought to (d) explore potential mechanisms contributing to change during positive CBT.

Method

Participants

The first 12 clients participating in the within-subject trial at the outpatient mood-disorder treatment unit of Virenze-Riagg Maastricht were asked by their therapist at the end of their treatment whether they would agree to take part in an interview with Emke Bosgraaf. Inclusion of participants ended when the reiterative analyses of interviews indicated a saturation of content for (a) previous expectations and (b) preference. Saturation was reflected in gaining no new information from the past four interviews. Regarding the questions (c) reasons for preference and (d) potential mechanisms contributing to change, the current study can be seen as the first explorative study, owing to the open-ended format of the questions. A larger replication study explicitly asking about the concepts clients brought up would be necessary to categorize clients' responses to these questions more systematically. All clients who were approached agreed to participate in the interview. Inclusion criteria for the positive CBT study were a current episode of MDD (diagnosis obtained through Structured Clinical Interview for *DSM-IV* Axis I Disorders; American Psychiatric Association, 2000) and fluency in the Dutch language. Use of antidepressant medication was allowed, as long as the medication was kept stable minimally 1 month before and during treatment. Exclusion criteria were bipolar disorder, borderline personality disorder, severe alcohol or drug abuse or addiction, and an IQ lower than 80. Given our small sample size and the fact that we were evaluating a new intervention, we additionally excluded participants whose current depressive episode lasted longer than 2 years (persistent major depression).

Table 1 displays demographic details and information about the therapeutic setting (sequence of the two approaches, therapist, earlier experience with CBT for depression, and whether or not Emke Bosgraaf the second author attended their treatment sessions for observation). We also included the 16-item Quick Inventory of Depressive Symptomatology (QIDS; Rush et al., 2003) score at baseline. Clients' baseline QIDS score (*M* 15.58, *SD* 2.87) varied between 10 and 20, and most were classified as suffering from moderate (13–16) to severe (17–20) depression (Rush et al., 2003).

Treatment

All participants received traditional and positive CBT in two blocks of eight sessions each (starting order randomized). Note that positive CBT is intended to be a stand-alone treatment (Bannink, 2012) but in the current study was provided in combination with traditional CBT owing to the need for within-subject measures in the larger, quantitative study (Geschwind et al., 2019). The starting order of treatment blocks had been randomized in blocks of four, separately for men and women. The treatment protocol for positive CBT was based on the book *Practicing Positive CBT* (Bannink, 2012; see also Bannink, 2014, and Geschwind et al., 2019). For traditional CBT, therapists used a shortened version of a standard CBT protocol for depression (Bockting & Huibers, 2011). See the introduction for more background on both treatments.

Therapists

Four therapists participated in the study (referred to as Therapists A–D in Table 1). This group consisted of a psychologist/researcher (A), a senior psychotherapist (B), and two health care psychologists (C and D). All therapists had moderate to extensive training in traditional CBT for depression. Their experience in treating patients with depression ranged from 2.5 to 20 years. Noteworthy is that the therapists were new to positive CBT and thus in the middle of a learning process at the start of the study.

All therapists followed a 2-day positive CBT training course guided by Fredrike Bannink in November 2014. After the study started, positive CBT supervision sessions of 60 min took place once every 2 weeks. Fredrike Bannink supervised the supervision meetings through Skype. The supervision meetings consisted of setting an agenda, voicing corrections to notes from the previous supervision meeting, sharing successes (to model the structure of positive CBT during supervision), and discussing updates on clients' progress, challenges, and questions. Especially in the beginning, specific positive CBT exercises were also practiced during the supervision sessions. Biweekly peer supervision for traditional CBT was standardly implemented in the healthcare institution.

Research Team

The research team was a mixed group, with three researchers working at the Faculty of Psychology and Neuroscience, Maastricht University. Emke Bosgraaf (who interviewed all participants and wrote the first draft of the article) works as a psychologist in a traditional treatment setting and has more than a decade of

Table 1
Respondent's Gender, Age, Depression at Baseline, and Treatment-Related Characteristics

Respondent	Gender	Age	QIDS (baseline)	Sequence of blocks	Therapist	Second author observed treatment[a]	Previously received CBT for depression
Resp 1	Male	41	16	Trad-Pos	A	No	No[b]
Resp 2	Female	59	13	Pos-Trad	A	No	No[b]
Resp 3	Female	24	10	Trad-Pos	A	No	No
Resp 4	Male	53	16	Pos-Trad	B	No	Yes (5 years ago, traditional CBT. Good effect but now recurrent episode.)
Resp 5	Female	20	17	Trad-Pos	C	No	No
Resp 6	Female	23	15	Pos-Trad	B	Yes	No
Resp 7	Male	50	20	Pos-Trad	A	No	No (received several therapies focused on chronic pain, though)
Resp 8	Female	26	11	Pos-Trad	A	No	No[b]
Resp 9	Male	32	16	Pos-Trad	A	No	No[b]
Resp 10	Female	51	18	Trad-Pos	A	Yes	No (received several therapies focused on trauma, though)
Resp 11	Female	36	16	Trad-Pos	C	No	Unclear: one (probably CBT-based) therapy 2 years ago
Resp 12	Female	19	19	Trad-Pos	D	Yes	No

Note. QIDS = 16-item Quick Inventory of Depressive Symptoms; CBT = cognitive behavioral therapy; Resp = respondent; Trad = traditional CBT; Pos = positive CBT.
[a] Because the second author wanted to attend at least one therapy trajectory with each therapist, a fourth treatment trajectory (with Therapist C) was observed. This client, however, was not interviewed due to scheduling problems. [b] These respondents reported receiving a couple of sessions prior to their referral to specialized care. Content and quality of these sessions is unknown, as most participants could give only vague descriptions. Based on their descriptions, participants were unlikely to have received full-blown CBT for depression previously.

experience conducting qualitative fieldwork in several settings. Nicole Geschwind and Frenk Peeters are researchers with a main interest in depression and resilience against depression. They combine their research with clinical activities, as a psychiatrist and psychologist, respectively. The psychologist-researcher participated as one of the therapists (Therapist A) in the research protocol. Fredrike Bannink has decades of experience in working with traditional CBT as well as with solution-focused brief therapy and positive psychology. The positive CBT protocol used in this study is based on her work.

Research Design

The theoretical underpinnings of our qualitative analysis can be placed within a constructivist–interpretive paradigm (Denzin & Lincoln, 2011). Although we have adopted the iterative, comparative, and interactive method from the grounded theory approach, we did not follow the classic inductive analytic process strictly. Our theoretical position aims for an interpretive understanding of qualitative data and is in line with Charmaz's (2011) stance on constructivist grounded theory. This means that inductive data collection contributes to theory formation in combination with explicitly acknowledging the researchers' roles in data construction and interpretation.

The fieldwork approach selected for our qualitative study can be described as a mixed research approach (Hennink, Hutter, & Bailey, 2011). Three qualitative methods were used: (a) in-depth interviews with clients, (b) direct participant observation (attending four treatment trajectories), and (c) indirect participant observation, through attendance of biweekly supervision (positive CBT) and intervision sessions (traditional CBT).

All interviews took place within 2 weeks after the last session and were held between July 2015 and July 2016. Informed consent was obtained from all participants, and study procedures complied with APA ethical principles. We ensured deidentification of all clinical case and interview material through masking of personal identifiers and limited presentation of quasi-identifiers. In addition, we quoted only completely anonymized interview excerpts. The interviews varied in length from 45 min to 2 hr and were audio recorded and transcribed verbatim. The Ethical Research Committee of Maastricht University approved the study (ECP-13201–09-2013). The interview format was developed in close collaboration with all four authors. Based on a literature search, Emke Bosgraaf drafted a preliminary format that was discussed and revised within the research group. After four interviews, the research group discussed the interview format and made minor revisions. The interview format consisted of 19 open questions (see Appendix). After a short introduction, the interviewer inquired about clients' expectations before the start of the therapy. He then asked to what extent the therapy met their expectations and which moment in therapy clients remembered most vividly. Subsequently, the interviewer asked two central questions "How did you experience positive/traditional CBT?" and "To what extent did positive/traditional CBT make you stronger in your daily life?", separately for positive and traditional CBT. The interview continued with questions about the overall (combined) treatment, for example, clients' experience of the sequence of positive and traditional CBT, their preference for either approach, and reasons for their preference. The interviewer also inquired whether clients had suggestions on how to improve their treatment.

Upon clients' permission, Emke Bosgraaf attended all treatment sessions (positive as well as traditional CBT) of three interviewees (Respondents 6, 10, and 12), as well as the sessions of a client who was not interviewed owing to scheduling problems on the researcher's side. The observed therapy trajectories covered all four therapists (A–D). The goal was to gain an in-depth understanding of the two approaches and to observe the therapeutic context on which the respondents reflected in the interviews.

Emke Bosgraaf also participated in supervision and intervision sessions of the four therapists and their supervisor. Next to indirect observation of clients' experiences with the treatment (through their therapists' eyes), this participation facilitated a complementary understanding of positive as well as traditional CBT from the perspective of the therapist.

Analysis

Consistent with qualitative analysis, we followed a cyclical analytical process in which data collection and analysis were alternated (Boeije, 2005). In the exploratory phase, qualitative software (Nvivo, Version 11) was used to organize data and to make an initial list of codes. Emke Bosgraaf coded the interviews and started with the open coding of three interviews. Subsequent thematic coding was guided by codes developed in open coding, using conventional content analysis (Hsieh & Shannon, 2005). Sensitizing concepts from the literature study on CBT, positive psychology and depression provided additional guidance (Bowen, 2006).

In the exploratory phase, we organized three sessions in which three authors participated: In the first session, Emke Bosgraaf presented the preliminary results based upon three interviews. Thereafter, two coding sessions took place (19th of January and 24th of May, 2016), in which each researcher coded two interviews independently. These sessions were used primarily to check, correct, and specify the first list of open codes and pattern codes (Boeije, 2005). In the second phase, a preliminary analysis was discussed in the research team. In the final phase (June–August, 2016), central themes were further developed and integrated.

Results

Previous Expectations Regarding Positive CBT

In particular about positive CBT, most interviewees reported having preset expectations before starting the therapy, see Table 2. The majority of the interviewees had initially sought treatment with the idea of talking about and tackling *problems*, rather than working toward their *preferred future* and zooming in on positive emotions. One interviewee who had started with positive CBT explained how she was initially biased against positive CBT: "At the start, I was quite skeptical. I really had this preconceived idea, that is, why do I have to talk about positive things when I am feeling so miserable?" (Respondent 2).

Next to these skeptical expectations, positive CBT was also associated with popular ideas about positive (or self-help) psychol-

Table 2
Previous Expectations Regarding Positive CBT and Eventual Preferences for Traditional CBT, Positive CBT, or a Combination of Both

Respondent	Favoring trad. CBT	Favoring pos. CBT	Combination of both	Previous expectations regarding pos. CBT
Resp 1	No opinion	No opinion	No opinion	No opinion
Resp 2	—	Yes: "Eventually positive CBT was really nice," though "not enough in itself"	Yes, *within* a session, with emphasis on positive CBT	Skeptical: "I need help with my problems first"
Resp 3	—	Yes: "very helpful"	No: "certainly not"	Mocking: "Optimism, I need a bucket . . ." (mimics throwing up)
Resp 4	—	—	Yes: "I needed both"	Carefully positive: perceives match with his previously optimistic personality
Resp 5	—	Yes: "The positive condition was actually nicer"	Yes: "Both are important to do"	Skeptical about therapy in general. "No idea really"
Resp 6	—	Yes: "60% positive versus 40% traditional CBT"	Yes: "The combination is necessary for finding a balance"	Skeptical: "Will that help me with my problems?"
Resp 7	No opinion	No opinion	No opinion	No opinion
Resp 8	—	Mentions foremost examples from positive CBT	"Both are useful"	No clear expectations: "wait and see"
Resp 9	—	Yes: "more radical than traditional CBT"	"The combination is also important"	Carefully positive: "might help"
Resp 10	—	Yes: strong preference for positive CBT	"Both are important"	Carefully positive: "suits me"
Resp 11	—	Yes: preference for positive CBT	No opinion	No clear idea: wait and see, "to down to care"
Resp 12	—	Yes: preference for positive CBT	"The therapy would be incomplete without trad. CBT"	Skeptical: "Need to address problems first"

Note. CBT = cognitive behavioral therapy; trad. = traditional; pos. = positive; Resp = respondent.

ogy, such as (mockingly): "[. . .] standing in front of a mirror and telling yourself: you're doing very well!" (Respondent 3).

However, some interviewees expressed a more optimistic view. The term *positive* here matched with a preliminary, hopeful idea that developing a more positive view could help against negative thinking patterns: "[. . .] because anyhow, I was being really [with emphasis] negative about my life and because it was positive CBT, I thought something like, who knows?" (Respondent 8).

A couple of respondents reported not having any specific ideas about positive CBT: "I was feeling so low, I did not care how I was helped. Wait and see. . ." (Respondent 11).

In sum, clients' previous expectations could be categorized as either (a) skeptical: Positive CBT will not tackle my problems because only positive things are part of this condition and I do not feel positive, (b) mocking: Positive CBT is probably vague and about glorifying oneself, or (c) tentatively positive: Positive CBT can perhaps be helpful in overcoming my problems. Of note, the initially skeptical or even mocking interviewees indicated that they had experienced a clear shift in their evaluation of positive CBT afterward, independent of the order of their treatment blocks. Thus, a clear discrepancy existed between low previous expectations of positive CBT and positive evaluations afterward.

Preferences

The majority of respondents (nine out of 12), given the choice for either one or the other, said that they would chose positive CBT, see Table 2. Eight out of these nine respondents indicated that the ideal treatment would be positive CBT, combined with aspects from traditional CBT. The ninth respondent (Respondent 3) strongly preferred positive CBT and felt that traditional CBT had not offered her anything useful. One respondent (Respondent 4) perceived the combination of both treatments as ideal. No one opted for traditional over positive CBT as the preferred main or only treatment.

Surprisingly, three respondents experienced their therapy as "one trajectory" and found it difficult to distinguish between the two CBT approaches (Respondents 1, 7, and 8). One interviewee (Respondent 8) experienced a carry-over effect: In traditional CBT, she continued to apply techniques from the previous block of positive CBT, in consequence diminishing the contrast. She was very satisfied with the results she achieved and referred mainly to positive CBT when asked about impactful moments. The other two respondents (Respondents 1 and 7) reported difficulty engaging with the treatment sessions. One of these two respondents (Respondent 1) emphasized that he did not have the time to reflect or engage with the therapy because of his demanding job and financial problems; the other (Respondent 2) stressed that he had concentration problems, a failing memory, and difficulty combining therapy with his fibromyalgia. Also, he had started therapy mainly to show his wife that he really could *not* change, thereby creating a self-fulfilling prophecy.

Another important observation is that the sequence of the two approaches had a large impact on the preferences of the interviewees. Of the six respondents who started with positive CBT and did experience a contrast, four interviewees (Respondents 2, 4, 6, and 9) stated that they would have preferred a change in sequence, starting with traditional CBT. The reasons for a preference to start with traditional CBT and then switch to positive CBT differed: Two interviewees found it unpleasant to focus on problematic situations after they had experienced the benefits of a positive focus (Respondents 2 and 9). Two interviewees (Respondents 4 and 6) would have preferred more room to talk about problems especially in the beginning of the therapy when the depression was still at its worst. They found it hard to address problems because they thought that it was essential to avoid talking about negative emotions or problems in positive CBT. This perception of positive CBT as "negative emotion-phobic" may have been influenced by several factors (among which the fact that therapists were relatively new to positive CBT; see section "Strengths and Limitations" in the discussion).

Reasons for Liking Positive CBT

Analysis of the interviews suggests that positive emotions played a key role in clients' preference for positive over traditional CBT. This statement is not meant to imply that traditional CBT does not elicit positive emotions. Interviewees also reported experiencing positive emotions within the traditional condition, for example, when receiving compliments from their therapist or when formulating thoughts that are more functional as an alternative to dysfunctional automatic thoughts. Equally, some of the quotes could also be interpreted as referring to traditional CBT. Nevertheless, the quotes are more typical for positive CBT, given that they highlight structurally used key concepts of positive CBT, and given that clients provided them in the context of discussing their experience with positive CBT.

Four distinct themes emerged as contributing to a preference for positive CBT over traditional CBT: (a) feeling good and empowered, (b) benefitting from the upward spiral effects of positive emotions, (c) learning to look for and appreciate baby steps toward the goal, and (d) (re)discovering optimism as a personal strength. We will now describe these themes in more detail.

Feeling good and empowered. Several respondents indicated that positive CBT was "actually much nicer" than traditional CBT. These experiences reveal the pleasantness of focusing on strengths, self-formulated goals, and things that are working, even in the context of a clinical depression. The following quote illustrates how a male interviewee experienced the impact of structurally focusing on what works in his life:

> And she [the therapist] said: So what else is working? I am sure there is much more. And I said: like what? She: what do you think about getting your own groceries? And cooking, you said you've cooked your own meal? I said: yeah, I've made spaghetti and that was nice. She: Well, that sounds positive to me. You've made your own meal! And I said, well yeah, but otherwise I do not get anything to eat. She: So you do the cooking! I: yeah . . . She: that seems to me to be something positive? I: okay . . . (Respondent 9)

Although ending his story in a hesitant way, the interviewee added that for him this moment was a game changer in the therapy. He became aware of the fact that there are many more positive things than he initially thought there would be. This helped him to feel better and to cope with his self-critical perfectionism (see also Barnes et al., 2013).

Another interviewee described her experience of the exercise "Best Possible Self." This exercise was used to generate a detailed

and vivid picture of the client's preferred future at the beginning of the positive CBT trajectory:

> We drew this line together showing what I wanted to achieve in my life within now and a year's time. And every session we talked about: Where are you now? Do you still remember your goal? And that is why you are working on it your whole life. This is my goal and I want to get to the top of that line. Then you are more conscious about it, and become more active: what do I want, what went well today, what went wrong and what can I do about that? I discovered that it is important to talk about myself, using a first-person perspective. (Respondent 3)

For this interviewee, talking about her goal from a first-person perspective represented a fundamental and empowering shift from what others (friends, boss, and family) wanted from her to what she wanted herself. Many of the other interviewees described a similar shift. They closely attributed this shift to first thinking about and formulating their goal, and subsequently making choices and taking steps that brought them closer to this goal.

Another defining characteristic of positive CBT is that several exercises involve active engagement with others. For example, in the exercise "Positive Self-Portrait," clients were invited to ask a minimum of five people to write about three instances in which the client had contributed something positive to their lives. Both the interviews and the observation of treatment sessions revealed that many interviewees were initially hesitant to ask for positive feedback. Afterward, their reluctance changed into contentment and satisfaction. Not only were clients proud that they had dared to do the exercise, they had also received warm and personal stories of family members and friends about their positive qualities, which in turn elicited more positive emotions:

> It was really those hurray moments that I experienced. And because of this I started to believe again, for the first time in my life, to really believe in myself. The exercise to ask positive feedback from other people made it clear to me: the way I am starting to see myself now, that is not something I imagine, no, it is being confirmed by other people. I have never realized that people experience me as they wrote in that letter. Positive, cheerful, taking initiative, you name it, such positive things that they wrote. And yes, I had never realized that [that I am worthwhile]. Slowly that realization started to grow during therapy. And if it is confirmed by the people you love, it has much more impact and more effect. (Respondent 10)

Benefitting from the upward spiral effects of positive emotions. Many interviewees described how the experience of positive emotions facilitated subsequent change in perception and behavior, and that positive emotions provided a buffer against the emotional consequences of stress. This second theme thus is closely connected to "upward spirals" of positive emotions (Garland et al., 2010) and the related "undoing effect" (Fredrickson, Mancuso, Branigan, & Tugade, 2000). For the sake of space, we highlight only two experiences.

The first experience illustrates the upward spiral effect of positive emotions. In this client's experience, the traditional CBT sessions were emotionally charged and difficult, although she experienced the cognitive part as very helpful. In the positive CBT sessions, however, the client increasingly talked about experiencing positive emotions such as happiness, contentment, love, trust, and generosity (therapy observation notes, Emke Bosgraaf). These positive emotional experiences induced a dramatic change process, which was strongly noticeable both during the therapy sessions (e.g., a lot of smiling, laughing, light-hearted atmosphere) and in her life (e.g., acquaintances telling her that she looked and behaved differently). In the interview afterward, she described that positive CBT gave her a "suit of armor to cope with problems and negative emotions" and that the biggest change for her was "the (new found) awareness that I am worthwhile" (Respondent 10).

The second experience shows a female participant's perception of the undoing effect:

> When you are in the middle of such a positive flow, your problems are less problematic and you are less concerned with them. They become less charged, because you are engaged in positive things. In this way, problems fade to the background. (Respondent 2)

Learning to look for and appreciate baby steps. A third theme that interviewees put forward is that they became more aware of the fact that a positive outlook on life can be learned through persistent practice (i.e., constantly practicing to identify and use baby steps and to appreciate them as small signs of progress). Many interviewees described how they felt before starting therapy. For example, they spoke about being so preoccupied with negative thoughts and events that they had no room for noticing positive features (i.e., negativity bias; Gotlib et al., 2004; Koster et al., 2010). Some clients tried to "use positive thinking" before their referral to the mental health center. They reported that it had not been helpful then, in retrospect because they had thought that "it should have been easy" (Respondent 3). In consequence, they had previously perceived themselves as unable to see things in a positive light and stopped trying. Nevertheless, the accounts of the interviewees indicated that adopting a positive instead of a negative focus can be learned through persistent practice and guidance.

Respondents described how structurally practicing to look for and appreciate positive elements as baby steps toward their goal was a crucial and essential element in the learning process. According to the interviewees, the challenge was to recognize small positive improvements (or to notice the things that were already working), and to see the merit of these positive elements. A female respondent expressed how hard this process was for her initially: "[. . .] that was something I found extremely difficult. I really tried to also look at those little things. Initially, I just didn't see them and it really took a couple of sessions before I was able to do it" (Respondent 12).

Once she was able to notice and appreciate positive elements, this interviewee described how she now consciously experienced positive emotions in situations that she had beforehand considered as "just ordinary moments" (e.g., cuddling with her daughter or having an evening off). She reported that, in turn, this built a buffer to cope with "moments that are less pleasant or the things I have to do." This buffer, in her experience, enabled her to invest effort toward her goal. Other interviewees shared her experience.

The (re)discovery of optimism as a personal strength. The (re)discovery of optimism was a recurrent theme in the interviews. We explicitly write (re)discovery, because for some respondents an optimistic outlook was completely new, whereas for others optimism was something they previously knew yet had lost during the depressive episode. Interviewees who characterized themselves

as previously having had an optimistic attitude described the appeal of positive CBT:

> Because I have a positive outlook on life [laughing]. Hhm, you wouldn't say that in the context of a depression, but I really am a positive person. So I had the idea that this could indeed help me to become more positive in my life. (Respondent 4)

During positive CBT, this interviewee rediscovered his lost optimism and could then use it to recover from depression more smoothly.

Observation of treatment trajectories and supervision suggested that self-identifying as (previously) having an optimistic attitude seemed to make the first steps in positive CBT easier and the pace of progress faster. Therapists reported that they needed to be more persistent when inviting self-identified pessimists to adopt a positive outlook. Nevertheless, interview analysis showed that self-identified optimism was not a necessary condition for benefitting from positive CBT. One respondent initially characterized himself as an "utter pessimist" (Respondent 9). In the end, however, he embraced what he called the "radical change in perspective of looking at positive things."

Compatible or Incompatible?

In the context of this trial, the two approaches were presented as different components belonging to one overall treatment (i.e., "we are looking at both sides of the coin"). The option of either positive or traditional CBT as a monotherapy had not been offered or discussed. Clients' perception of the compatibility of the two approaches varied. Some interviewees highlighted the strength of combining traditional with positive CBT. For example, one respondent explained that during his off-days he used techniques from traditional CBT to structure and analyze his negative thoughts in addition to using positive CBT techniques such as intentionally looking at what went well that particular day (Respondent 4). Another respondent perceived both approaches as contributing to a balance. Positive CBT made her stronger by "pausing for a moment, in particular paying attention to positive things," whereas traditional CBT helped her to "not stay absorbed in negative thoughts and move on to realistic ones" (Respondent 6).

Some interviewees who stressed the importance of combining both positive and traditional CBT, simultaneously expressed critical notes regarding traditional CBT. One respondent argued that traditional CBT, in her experience, had been difficult and unpleasant, but necessary because it had taught her the basic skill of scrutinizing her thoughts (Respondent 10). Another respondent viewed traditional CBT as helpful and necessary for understanding her depression, including trigger points. However, in her opinion positive CBT presented a crucial second step: finding solutions and useful tools to start living a life in line with her values (Respondent 12).

Other respondents, especially those who had started starting with positive CBT, described that they experienced the two approaches as interfering with each other. One interviewee remembered "getting a boost" from talking about and searching for positive things in her life. However, after improving during positive CBT, she felt that her mood was deteriorating during traditional CBT:

> First, with the positive, that's really positive, you improve like being in a flow [makes a gesture upwards with her hand], and then after you had these eight sessions, you continue with problems and then you go [makes a downwards gesture]. (Respondent 2)

Another respondent remarked on the benefits of looking for explicitly positive, rather than neutral or realistic thoughts: "Changing your thought pattern into a positive one is healthier for people with a depression than the traditional approach" (Respondent 9).

Discussion

Traditionally, psychotherapy has largely focused on problem behavior (with behavior here broadly defined as including thoughts and emotions). Also, in traditional CBT protocols for depression (i.e., protocols based on Beck et al., 1979), the overall focus is on examining automatic thoughts during problem instances and subsequently identifying more realistic and helpful thoughts and behaviors. Recently, the therapeutic focus has shifted from repairing damage (i.e., achieving remission of symptoms) to the promotion of flourishing and positive mental health (Santos et al., 2013; Seligman, 2013; Slade, 2010). This does not imply that problem-focused approaches do not elicit positive emotions or do not highlight client's strengths and coping mechanisms. However, some recently developed approaches more structurally and explicitly target positive emotions and strengths. Examples of these approaches are augmented depression therapy (Dunn et al., 2019), positive affect treatment (Craske et al., 2019), or positive CBT (Bannink, 2012).

Positive CBT structurally focuses on clients' preferred future, strengths, and exceptions to problems. Problems (including their origins or maintaining factors) are not discussed in detail. A recent study in 49 participants with MDD (who received eight sessions of positive CBT and eight sessions of traditional CBT as separate elements of their treatment) found that positive CBT was associated with more clinically significant change, compared with traditional CBT (Geschwind et al., 2019). The current study in a subset of these participants is the first to investigate clients' experience of positive CBT. In the following text, we highlight the major outcomes and link them to the broaden-and-build theory of positive emotions (Fredrickson, 2004).

Positive CBT Is Enjoyable

Most respondents indicated a preference for positive CBT compared with traditional CBT. Qualitative analysis shows that positive emotions played a central role in liking positive CBT. Although positive CBT was not always experienced as easy, especially not in the early phases of therapy, many respondents experienced this treatment approach as pleasant and looked forward to the next session. According to the interviewees, what made positive CBT enjoyable was the focus on strengths and things that worked in the clients' lives, in combination with the goal-oriented approach. Another reason for clients' overall liking of positive CBT was the (for many clients unexpected) realization that they *can* develop a more positive focus through persistently looking for better moments and subsequently designing and taking baby steps.

Resilience and Change

Many interviewees indicated that positive CBT helped them to feel stronger in their daily lives, mainly through showing them the benefits and possibilities of an alternative (cognitive/attentional) perspective, and through offering them the tools to practice this shift in perspective. In clients' experience, positive CBT, with its structural focus on developing a more positive perspective on life, automatically reduced the influence of negative emotions. This corresponds to the undoing effect of positive emotions (Fredrickson et al., 2000) and is in line with the quantitative analysis of the larger within-subject study: Positive CBT was associated with a higher rate of clinically significant change in negative affect and depression, compared with traditional CBT (Geschwind et al., 2019). In contrast, although most clients experienced traditional CBT as insightful, some clients reported that the focus on problems (moments associated with negative emotions) in traditional CBT was emotionally difficult and sometimes felt counterproductive to their well-being. Clients' accounts connect with previous research in the sense that the emotional aversiveness of focusing on problems has been reported as a reason for dropout from therapy (Barnes et al., 2013; Kahlon, Neal, & Patterson, 2014). Also, in the larger quantitative study, significantly more dropout happened during traditional CBT rather than positive CBT sessions (Geschwind et al., 2019).

Another change related to positive CBT is the (re)discovery of optimism as a personal strength. Optimistic cognitive styles have been associated with "invulnerability to depression" (Abramson et al., 2000). Positive CBT helped clients to reconnect with their previously optimistic nature, or, for the more pessimistic clients, to see things from a radically different perspective.

According to the broaden-and-build theory, positive emotions can result in the broadening of thought–action repertoires, which subsequently lead to beneficial interactions between intellectual, psychological, and social resources (Fredrickson, 2004). In the qualitative analysis of the changes described by the interviewees, these interactions seem to have taken place. Positive CBT, in particular the practice of (re)directing attention to better moments and strengths, was experienced as "something new" that was "hard, but possible to learn" (an intellectual resource). The resulting feelings of empowerment led to an increase in psychological resources such as optimism and self-esteem. Participants also regularly described a profound impact in the area of social resources: The new-found intellectual and psychological resources either deepened relationships with partners and friends (e.g., choosing to invest in friendships, and expressing gratitude) or dissolved relationships (e.g., deciding to get rid of contacts who exerted a bad influence). These changes also correspond with Seligman's concept of flourishing and the five underlying factors contributing to flourishing according to the PERMA model (Positive emotions, Engagement, Relationships, Meaning, and Accomplishment; Seligman, 2013).

Preferences and Previous Expectations

As a stand-alone therapy, most interviewees would have chosen positive CBT. Although the interviewees preferred positive CBT, most of them perceived the combination of both conditions as useful and would have added traditional CBT elements to positive CBT. In the context of being offered a therapy consisting of two sequenced treatment blocks, most interviewees would have preferred to start with traditional and end with positive CBT. The reasons for preferring such a sequence differed: Some interviewees found it unpleasant to switch to monitoring problems after they had experienced the benefits of having a positive focus. Others saw it as crucial to first talk about their problems, especially at the start of therapy.

Both clients and therapists experienced the focus on better moments and strengths as a paradigm shift that took time to learn. Clients' previous expectations fell into three categories (skeptic, mocking, or carefully positive). Especially clients belonging to the first two subgroups initially came to therapy sessions with the idea to talk about their problems. Repeatedly explaining the rationale for focusing on positive emotions and exceptions to problems was imperative for ensuring these clients' cooperation. This is in line with what Levitt and colleagues (2016) have called the importance of "what the client is bringing to therapy" (p. 824). Clients' expectations thus provide starting points for setting the focus and the pace of therapy. Regular supervision was necessary to help the therapists to learn how to balance between acknowledging the existence of problems (without going into detail), while simultaneously looking for openings to talk about clients' strengths, exceptions to problems, and baby steps toward their preferred future.

Interestingly, also the initially skeptic or mocking subgroups reported a preference for positive CBT afterward. This preference for an explicit focus on positive emotions corresponds with Zimmerman and colleagues' (2006) qualitative analysis of what clients want from therapy: optimism, self-confidence, and other features of positive mental health, next to a return to their usual level of functioning. Note that the term *preference* as used in the current study refers to an experientially formed preference (after experiencing both forms of CBT), rather than to preferences expressed before starting the therapy. These eventual preferences were not necessarily reflected in clients' previous (and uninformed) expectations of positive CBT. Our results suggest that, by connecting with client preferences better, a more structural and explicit focus on better moments, strengths, and positive emotions may be beneficial in terms of both enhancing outcome and reducing dropout in treatment for depression.

Strengths and Limitations

The following three strengths are worth mentioning: First, this is the first time that experiences of clients with positive CBT were investigated. Second, clients were actively seeking therapy, and most were moderate to severely depressed, which enhances external validity. Third, owing to the within-subjects design, clients could contrast their experience with positive CBT to their experience of traditional CBT, resulting in a wealth of qualitative information.

However, the current study also suffers from the following limitations. First, the characteristics of the research design exerted a considerable influence on the experiences of both traditional and positive CBT. To study the contrast between the two different approaches, we needed to separate them strictly, probably more strictly than necessary in routine clinical practice. Therapists followed a standardly used protocol and were instructed to perform traditional CBT as they normally would. Nevertheless, this separation may have induced demand characteristics, for example, therapists being positive-emotion-phobic in traditional CBT, or the

opposite, problem-phobic in positive CBT. In addition, owing to the research design, we could only approach treatment completers. Future studies could compare experiences with traditional CBT and positive CBT *between* participants, and/or also address the experiences of people who dropped out of therapy.

Second, the therapists in this study had just started to learn positive CBT and were still in a learning process. Therapists sometimes found it difficult to find a balance between acknowledging clients' struggles and looking for openings to invite a shift in focus from "what is wrong with me" to "what is right with me." Having therapists with more experience in positive CBT may have led to different perceptions regarding the optimal balance between positive and traditional CBT.

Third, no fidelity or competence measures for positive CBT are available yet. For both positive and traditional CBT, supervision and intervision were used to safeguard quality of delivery, but fidelity and competence were not formally assessed.

Fourth, the qualitative approach we used (a constructivist–interpretative paradigm integrating information from three different sources [interviews, supervision, and therapy trajectories]) maximizes the available information but leaves more room for interpretation, compared with a classic inductive analytic process. Given that this was a first explorative study of clients' experiences with positive CBT, a replication in a larger sample (using the concepts respondents brought up in the current study) would be useful to investigate the universality of mechanisms of change in positive CBT more systematically.

Conclusion

Our qualitative analysis shows that structurally focusing on positive emotions, strengths, and better moments (as in positive CBT) has promising therapeutic merit in face-to-face psychotherapy for treating depression. Even though many respondents (all diagnosed with MDD) reported initial skepticism toward a focus on positive emotions, the majority preferred positive over traditional CBT after completion of the treatment trajectory and reported experiencing a steeper learning curve during positive CBT. Most respondents would have added some elements of traditional CBT to positive CBT, though, and found it important to receive recognition for the problems they were struggling with. Overall, positive CBT was experienced as pleasant and seems to have led to substantial changes in psychological, intellectual, and social resources.

The main advantage of positive CBT appears to be that clients perceive the focus on better moments and the accompanying positive emotions as *challenging but enjoyable* during the sessions. The experience of positive emotions in turn created a buffer against negative emotions, in line with Fredrickson's (2004) broaden-and-build theory. Next to contributing to flourishing, positive emotions can therefore have a serious impact on overcoming possible barriers during therapy and could help with engagement and completion of therapy (see also Barnes et al., 2013). The conclusion emerging from this study is that exploring better moments and building positivity efficiently counters depressive symptoms and builds well-being. Interviewees appreciated the lightness of tone; they mentioned shared fun and laughter during sessions as memorable, motivating, and empowering.

References

Abramson, L., Alloy, L., Hankin, B., Clements, C., Zhu, L., & Whitehouse, W. (2000). Optimistic cognitive styles and invulnerability to depression. *Laws of Life Symposia Series, 2,* 75–98.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Arnold, J. F., Fitzgerald, D. A., Fernández, G., Rijpkema, M., Rinck, M., Eling, P. A., . . . Tendolkar, I. (2011). Rose or black-coloured glasses? Altered neural processing of positive events during memory formation is a trait marker of depression. *Journal of Affective Disorders, 131,* 214–223. http://dx.doi.org/10.1016/j.jad.2010.12.011

Bannink, F. (2012). *Practicing positive CBT: From reducing distress to building success*. Chichester, United Kingdom: Wiley, Ltd. http://dx.doi.org/10.1002/9781118328941

Bannink, F. (2014). Positive CBT: From reducing distress to building success. *Journal of Contemporary Psychotherapy, 44,* 1–8. http://dx.doi.org/10.1007/s10879-013-9239-7

Bannink, F., & Jackson, P. Z. (2011). Positive psychology and solution focus—looking at similarities and differences. *InterAction: The Journal of Solution Focus in Organisations, 3,* 8–21.

Barnes, M., Sherlock, S., Thomas, L., Kessler, D., Kuyken, W., Owen-Smith, A., . . . Turner, K. (2013). No pain, no gain: Depressed clients' experiences of cognitive behavioural therapy. *British Journal of Clinical Psychology, 52,* 347–364. http://dx.doi.org/10.1111/bjc.12021

Beck, A. T., Rush, A. J., Shaw, B. F., & Emergy, G. (1979). *Cognitive therapy of depression*. New York, NY: Guilford Press.

Bockting, C., & Huibers, M. (2011). Protocollaire behandeling van patiënten met een depressieve stoornis [Protocol-based treatment of patients with major depressive disorder]. In G. P. J. Keijsers, A. van Minnen, & C. A. L. Hoogduin (Eds.), *Protocollaire behandelingen voor volwassenen met psychische klachten* [Protocol-based treatments in adults with psychological complaints] (pp. 251–288). Amsterdam, the Netherlands: Boom.

Boeije, H. (2005). *Analyseren in kwalitatief onderzoek. Denken en doen* [Analyses in qualitative research. Thinking and doing]. Amsterdam, the Netherlands: Boom.

Bohart, A. C., & Tallman, K. (2010). Clients: The neglected common factor in psychotherapy. In B. Duncan, S. Miller, B. Wampold, & A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 83–111). Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/12075-003

Bolier, L., Haverman, M., Westerhof, G. J., Riper, H., Smit, F., & Bohlmeijer, E. (2013). Positive psychology interventions: A meta-analysis of randomized controlled studies. *BMC Public Health, 13,* 119. http://dx.doi.org/10.1186/1471-2458-13-119

Bowen, G. A. (2006). Grounded theory and sensitizing concepts. *International Journal of Qualitative Methods, 5,* 12–23. http://dx.doi.org/10.1177/160940690600500304

Charmaz, K. (2011). Grounded theory methods in social justice research. In N. K. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (4th ed., pp. 359–380). Thousand Oaks, CA: Sage.

Craske, M. G., Meuret, A. E., Ritz, T., Treanor, M., & Dour, H. J. (2016). Treatment for anhedonia: A neuroscience driven approach. *Depression and Anxiety, 33,* 927–938. http://dx.doi.org/10.1002/da.22490

Craske, M. G., Meuret, A. E., Ritz, T., Treanor, M., Dour, H., & Rosenfield, D. (2019). Positive affect treatment for depression and anxiety: A randomized clinical trial for a core feature of anhedonia. *Journal of Consulting and Clinical Psychology, 87,* 457–471. http://dx.doi.org/10.1037/ccp0000396

Cuijpers, P., Sijbrandij, M., Koole, S. L., Andersson, G., Beekman, A. T., & Reynolds, C. F., III. (2013). The efficacy of psychotherapy and pharmacotherapy in treating depressive and anxiety disorders: A meta-analysis of direct comparisons. *World Psychiatry, 12,* 137–148. http://dx.doi.org/10.1002/wps.20038

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2011). Introduction: The discipline and practice of qualitative research. In *Handbook of qualitative research* (4th ed., pp. 1–19). Thousand Oaks, CA: Sage.

De Shazer, S., Dolan, Y., Konnan, H., & Berg, I. K. (2012). *More than miracles: The state of the art of solution-focused brief therapy*. Abingdon, United Kingdom: The Haworth Press. Retrieved from https://www.amazon.com/More-Than-Miracles-Solution-Focused-Therapy/dp/0789033984

Driessen, E., & Hollon, S. D. (2010). Cognitive behavioral therapy for mood disorders: Efficacy, moderators and mediators. *Psychiatric Clinics of North America, 33,* 537–555. http://dx.doi.org/10.1016/j.psc.2010.04.005

Dunlop, B. W., Kelley, M. E., Aponte-Rivera, V., Mletzko-Crowe, T., Kinkead, B., Ritchie, J. C., . . . Crowe, T. M. (2017). Effects of patient preferences on outcomes in the predictors of remission in depression to individual and combined treatments (PReDICT) study. *The American Journal of Psychiatry, 174,* 546–556. http://dx.doi.org/10.1176/appi.ajp.2016.16050517

Dunlop, B. W., LoParo, D., Kinkead, B., Mletzko-Crowe, T., Cole, S. P., Nemeroff, C. B., . . . Craighead, W. E. (2019). Benefits of sequentially adding cognitive-behavioral therapy or antidepressant medication for adults with nonremitting depression. *The American Journal of Psychiatry, 176,* 275–286. http://dx.doi.org/10.1176/appi.ajp.2018.18091075

Dunn, B. D. (2012). Helping depressed clients reconnect to positive emotion experience: Current insights and future directions. *Clinical Psychology and Psychotherapy, 19,* 326–340. http://dx.doi.org/10.1002/cpp.1799

Dunn, B. D. (2019). Augmenting cognitive behavioural therapy to build positive mood in depression. In J. Gruber (Ed.), *Oxford handbook of positive emotion and psychopathology* (pp. 539–560). New York, NY: Oxford University Press. http://dx.doi.org/10.1093/oxfordhb/9780190653200.013.33

Dunn, B. D., Widnall, E., Reed, N., Taylor, R., Owens, C., Spencer, A., . . . Kuyken, W. (2019). Evaluating augmented depression therapy (ADepT): Study protocol for a pilot randomised controlled trial. *Pilot and Feasibility Studies, 5,* 63. http://dx.doi.org/10.1186/s40814-019-0438-1

Emmons, R. A., & McCullough, M. E. (2003). Counting blessings versus burdens: An experimental investigation of gratitude and subjective well-being in daily life. *Journal of Personality and Social Psychology, 84,* 377–389. http://dx.doi.org/10.1037/0022-3514.84.2.377

Fredrickson, B. L. (2004). The broaden-and-build theory of positive emotions. *Philosophical Transactions of the Royal Society of London Series B, Biological Sciences, 359,* 1367–1377. http://dx.doi.org/10.1098/rstb.2004.1512

Fredrickson, B. L., Mancuso, R. A., Branigan, C., & Tugade, M. M. (2000). The undoing effect of positive emotions. *Motivation and Emotion, 24,* 237–258. http://dx.doi.org/10.1023/A:1010796329158

Garland, E. L., Fredrickson, B., Kring, A. M., Johnson, D. P., Meyer, P. S., & Penn, D. L. (2010). Upward spirals of positive emotions counter downward spirals of negativity: Insights from the broaden-and-build theory and affective neuroscience on the treatment of emotion dysfunctions and deficits in psychopathology. *Clinical Psychology Review, 30,* 849–864. http://dx.doi.org/10.1016/j.cpr.2010.03.002

Geschwind, N., Arntz, A., Bannink, F., & Peeters, F. (2019). Positive cognitive behavior therapy in the treatment of depression: A randomized order within-subject comparison with traditional cognitive behavior therapy. *Behaviour Research and Therapy, 116,* 119–130. http://dx.doi.org/10.1016/j.brat.2019.03.005

Geschwind, N., Nicolson, N. A., Peeters, F., van Os, J., Barge-Schaapveld, D., & Wichers, M. (2011). Early improvement in positive rather than negative emotion predicts remission from depression after pharmacotherapy. *European Neuropsychopharmacology, 21,* 241–247. http://dx.doi.org/10.1016/j.euroneuro.2010.11.004

Gorwood, P., Demyttenare, K., Vaiva, G., Corruble, E., Llorca, P. M., Bayle, F., & Courtet, P. (2015). An increase in joy after two weeks is more specific of later antidepressant response than a decrease in sadness. *Journal of Affective Disorders, 185,* 97–103. http://dx.doi.org/10.1016/j.jad.2015.06.019

Gotlib, I. H., Krasnoperova, E., Yue, D. N., & Joormann, J. (2004). Attentional biases for negative interpersonal stimuli in clinical depression. *Journal of Abnormal Psychology, 113,* 127–135. http://dx.doi.org/10.1037/0021-843X.113.1.121

Hallas, R. (2014). *Narratives of clients' experiences of cognitive behavioural therapy*. Retrieved from http://mro.massey.ac.nz/bitstream/handle/10179/6384/01_front.pdf?sequence=1&isAllowed=y

Hennink, M., Hutter, I., & Bailey, A. (2011). *Qualitative research methods*. London, United Kingdom: SAGE publications.

Hodgetts, A., & Wright, J. (2007). Researching clients' experiences: A review of qualitative studies. *Clinical Psychology and Psychotherapy, 14,* 157–163. http://dx.doi.org/10.1002/cpp.527

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15,* 1277–1288. http://dx.doi.org/10.1177/1049732305276687

Kahlon, S., Neal, A., & Patterson, T. G. (2014). Experiences of cognitive behavioural therapy formulation in clients with depression. *Cognitive Behaviour Therapist, 7,* e8. http://dx.doi.org/10.1017/S1754470X14000075

Koster, E. H. W., De Raedt, R., Leyman, L., & De Lissnyder, E. (2010). Mood-congruent attention and memory bias in dysphoria: Exploring the coherence among information-processing biases. *Behaviour Research and Therapy, 48,* 219–225. http://dx.doi.org/10.1016/j.brat.2009.11.004

Levitt, H. M., Pomerville, A., & Surace, F. I. (2016). A qualitative meta-analysis examining clients' experiences of psychotherapy: A new agenda. *Psychological Bulletin, 142,* 801–830. http://dx.doi.org/10.1037/bul0000057

Lindhiem, O., Bennett, C. B., Trentacosta, C. J., & McLear, C. (2014). Client preferences affect treatment satisfaction, completion, and clinical outcome: A meta-analysis. *Clinical Psychology Review, 34,* 506–517. http://dx.doi.org/10.1016/j.cpr.2014.06.002

Rush, A. J., Trivedi, M. H., Ibrahim, H. M., Carmody, T. J., Arnow, B., Klein, D. N., . . . Keller, M. B. (2003). The 16-Item Quick Inventory of Depressive Symptomatology (QIDS), Clinician Rating (QIDS-C), and Self-Report (QIDS-SR): A psychometric evaluation in patients with chronic major depression. *Biological Psychiatry, 54,* 573–583. http://dx.doi.org/10.1016/S0006-3223(02)01866-8

Santos, V., Paes, F., Pereira, V., Arias-Carrión, O., Silva, A. C., Carta, M. G., . . . Machado, S. (2013). The role of positive emotion and contributions of positive psychology in depression treatment: Systematic review. *Clinical Practice and Epidemiology in Mental Health, 9,* 221–237.

Seligman, M. E. P. (2006). *Learned optimism: How to change your mind and your life* (Vol. 9). London, United Kingdom: Nicholas Brealey Publishing.

Seligman, M. E. P. (2013). *Flourish: A visionary new understanding of happiness and well-being*. New York, NY: Atria Paperback.

Seligman, M. E. P., Rashid, T., & Parks, A. C. (2006). Positive psychotherapy. *American Psychologist, 61,* 774–788. http://dx.doi.org/10.1037/0003-066X.61.8.774

Sewart, A. R., Zbozinek, T. D., Hammen, C., Zinbarg, R. E., Mineka, S., & Craske, M. G. (2019). Positive affect as a buffer between chronic stress and symptom severity of emotional disorders. *Clinical Psychological Science, 7,* 914–927. http://dx.doi.org/10.1177/2167702619834576

Sin, N. L., & Lyubomirsky, S. (2009). Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: A practice-friendly meta-analysis. *Journal of Clinical Psychology, 65,* 467–487. http://dx.doi.org/10.1002/jclp.20593

Slade, M. (2010). Mental illness and well-being: The central importance of positive psychology and recovery approaches. *BMC Health Services Research, 10,* 26. http://dx.doi.org/10.1186/1472-6963-10-26

Strunk, D. R., Adler, A. D., & Hollon, S. D. (2016). Cognitive therapy of depression. In R. J. DeRubeis & D. R. Strunk (Eds.), *The Oxford handbook of mood disorders* (Vol. 1, pp. 1–23). Oxford, United Kingdom: Oxford University Press.

Valkonen, J., Hänninen, V., & Lindfors, O. (2011). Outcomes of psychotherapy from the perspective of the users. *Psychotherapy Research, 21,* 227–240. http://dx.doi.org/10.1080/10503307.2010.548346

Vazquez, C., Duque, A., Blanco, I., Pascual, T., Poyato, N., Lopez-Gomez, I., & Chaves, C. (2018). CBT and positive psychology interventions for clinical depression promote healthy attentional biases: An eye-tracking study. *Depression and Anxiety, 35,* 966–973. http://dx.doi.org/10.1002/da.22786

Widnall, E., Price, A., Trompetter, H., & Dunn, B. D. (2019). Routine cognitive behavioural therapy for anxiety and depression is more effective at repairing symptoms of psychopathology than enhancing wellbeing. *Cognitive Therapy and Research*. Advance online publication. http://dx.doi.org/10.1007/s10608-019-10041-y

Zimmerman, M., McGlinchey, J. B., Posternak, M. A., Friedman, M., Attiullah, N., & Boerescu, D. (2006). How should remission from depression be defined? The depressed patient's perspective. *The American Journal of Psychiatry, 163,* 148–150. http://dx.doi.org/10.1176/appi.ajp.163.1.148

Appendix

Interview Format

Introduction

Check whether respondents remember that the interview will be recorded and whether they still agree to that, and review privacy rules. Make clear that I did not have access to their treatment details and that this interview does not take place in a therapeutic setting. Introduce myself as involved in the research project. Briefly recap the goal of this qualitative research project, explain that I am interested in their personal experiences, that I have some prespecified questions but will follow them up with other questions to gain insight into their experience. Provide information on the structure and duration of the interview (1–1.5 hr) and that they can ask for a break whenever they want to. Clarify use of terms in this interview (therapy as a whole, traditional CBT, positive CBT). Use respondents' terminology if they prefer that. Check which approach they started with. Leave room for questions.

Questions:

A) Therapy as a whole

1) Which image or ideas did you have about the treatment before you started?

2) Did your experience of the treatment match the image you had beforehand?

3) Can you name a moment (or a couple of moments) in the therapy that has (have) stayed with you the most? Follow-up with questions on the nature of their experiences (e.g., pleasant/unpleasant/difficult?)

4) Looking back at the entire therapy, what has helped you most?

B) Positive CBT

5) How did you experience "positive CBT" (ask as much as possible about specific situations/experiences)? Clarify through subquestions: What do you mean with well-being? What do you mean with positive feelings? If a respondent mentions other terms, ask what these mean to the respondent (e.g., think of happiness, quality of life, hope, optimism, etc.). Also ask how respondents perceived the positive CBT session opening question "What is better since the last time we met?"

6) Looking back at the different elements of this (positive CBT) approach, which ones do you remember in particular?

7) To what extent has positive CBT made you stronger in your daily life?

(*Appendix continue*)

C) Traditional CBT

8) How did you experience traditional CBT? (ask as much as possible about specific situations/experiences)? Analogue to Question 5, clarify terms through subquestions: What do you mean with . . .

9) To what extent has traditional CBT made you stronger in daily life?

10) To what extent did you experience keeping track of exceptions to problems as different to keeping track of problem situations? (Also ask whether respondents had a clear preference in advance and whether their experience has changed during the course of the therapy.)

11) How did you experience the switch between the traditional and positive CBT parts? (Ask to clarify, e.g., as a break or as a smooth transition?)

D) Therapy as a whole

12) To what extent have you started looking differently at yourself or at your goal in life through treatment? What has helped you most in this? Check whether answer fits with concept of recovery ("back to the old self") or rather transformation (emerging as different or stronger).

13) How did you experience the contact with your therapist? Follow up whether (and if so, how) this differed in the two different approaches.

14) Have you ever thought about stopping therapy? If so, how did that happen? What made you continue?

15) How did your loved ones react to the therapy? Ask about specific parts that were particularly impactful.

16) You have completed the entire therapy: What do you think could be areas for improvement?

E) Closing

17) Which focus did you prefer? Can you tell me more about this?

18) What would be the best combination between the two different approaches, based on your own experience? What did you think about combining the two approaches within one treatment, was that valuable for you or not?

19) Are there any points that we have not yet spoken about, but which you think are important to mention?

Thank respondent for his or her time, explain what will happen with their data (e.g., recording securely stored, information only used anonymously).

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Correction to Geschwind et al. (2020)

In the article "Positivity Pays Off: Clients' Perspectives on Positive Compared With Traditional Cognitive Behavioral Therapy for Depression" by Nicole Geschwind, Emke Bosgraaf, Fredrike Bannink, and Frenk Peeters (*Psychotherapy*. Advance online publication. February 20, 2020. http://dx.doi.org/10.1037/pst0000288), the second to last sentence does not appear correctly and should appear instead as follows: The conclusion emerging from this study is that exploring better moments and building positivity efficiently counters depressive symptoms and builds well-being.

All versions of this article have been corrected.

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